Childrens Heart Center Nevada

continuous care for the fetus, child & adult with congenital heart disease

Authorization for the Release of Protected Health Information (PHI)

Patient Name: _____ D.O.B. _____

Gender at birth: ☐ M ☐ F Gender Identity: ☐ M ☐ F ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer ☐ Other _____ ☐ Prefer not to answer

Address: _____
Street *City* *State* *Zip*

Phone: _____ Email: _____

The Purpose for this disclosure:
☐ My request (parent/patient ONLY) ☐ Payment/Insurance ☐ Healthcare ☐ Employment ☐ Other _____

How should the information be released (if left blank, a paper copy will be provided)?
☐ Paper copy ☐ Secure messaging *must be signed up for the patient portal
☐ Facsimile ☐ Media (USB/CD)*password protected
Note: In the event that the facility is unable to accommodate an electronic delivery as requested, an alternate delivery method will be provided (e.g.; paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving encrypted media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g.; virus) potentially introduced to your computer/device when receiving PHI in electronic format or via email.

Description of information to be used or disclosed:
☐ All records ☐ Office reports ☐ Hospital Reports ☐ Surgery Reports ☐ EKG/Echo ☐ Labs
☐ Mental Health records (signature required)_____
☐ Genetics (signature required)_____ ☐ Other _____

This authorization will expire 12 months from today's date:
☐ Date _____

Protected Health Information (PHI) can be released to/from the following individuals/companies:

Name: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

Name: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

Name: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

Name: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

Name: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

Name: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

Name: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

I understand that:

1. Upon completion of a visit, corroborating medical records are automatically forwarded to the referring physician.
2. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization. I can refuse to sign this form, as it is voluntary.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on actions taken prior to receiving the revocation. Further details can be found in the HIPAA notices.
4. If the requester or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. Medical records copied for reasons other than continuity of care are subject to a copy fee (NRS 629.061). These include but are not limited to legal requests, investigative agencies, insurance companies, and patient personal use requests. Multiple copies will be charged for.
6. CHC will take precautions to avoid improper access to PHI but I acknowledge that if I lose the CD and/or password, they are stolen from my possession, or if I allow another person access to the CD/password, CHC will not be liable for any resulting unauthorized access under any circumstances.
7. I am aware that if medical notes are requested, the mental health notes are not automatically released and are in fact kept separate from all other clinic notes.
8. This PHI is in fact null and void without the signature of the patient (if 18 or older), parent or legal guardian.

I have read the above and authorize the disclosure of the protected health information as stated:	
Signature of Patient/ Patient's Representative:	Date:
Print Name of Patient/ Patient's Representative:	Relationship to Patient:

All items on this authorization form must be completed or request may not be honored.

Southern Nevada
3131 La Canada St., Ste 230
Las Vegas, NV 89169
Call: (702) 732-1290 Toll Free: (866) 732-1290
Fax: (702) 732-1385
Email: HIM@chcnv.org

Northern Nevada
85 Kirman Ave, Ste 401
Reno, NV 89502
Call: (775) 324-6644 Toll Free: (877) 732-1290
Fax: (775) 322-4748
Email: HIMReno@chcnv.org